Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ALLIED MEDICAL CENTERS

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-11-4667-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
AUGUST 9, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent a status request and a request for reconsideration which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.240."

Amount in Dispute: $435.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2011 January 13, 2011	CPT Code 97110-GP (X2 units)	$112.00/each	$190.56
January 12, 2011 January 13, 2011	CPT Code 97112-GP	$56.00/each	$99.58
January 13, 2011	CPT Code 97124-GP	$43.00	$38.88
January 12, 2011	CPT Code 97140-GP	$56.00	$44.91
TOTAL		$435.00	$373.93

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.

3. Neither party to this dispute submitted explanation of benefits to support denial of reimbursement.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307(c)(2)(B)?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(B), requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the requestor submitted bills to Ace American Insurance via facsimile and supports carrier receipt of the bill. The Division concludes that the requestor has met the requirements of §133.307(c)(2)(B). Therefore, the disputed services will be reviewed per applicable Division rules and guidelines.
2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2011 DWC conversion factor for this service is 54.54.

   The Medicare Conversion Factor is 33.9764

   Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas; therefore, the Medicare participating amount is based upon the locality of "Houston, Texas".

Code	Medicare Participating Amount	MAR	Amount Paid	Amount Due
97110	$29.68	$47.64 X 2units = $95.28/day X 2 days = $190.56	$0.00	$190.56
97112	$31.02	$49.79 X 2 days = $99.58	$0.00	$99.58
97140	$27.98	$44.91	$0.00	$44.91
97124	$24.22	$38.88	$0.00	$38.88

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Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $373.93.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $373.93 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		04/30/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.